SHARED WORK PLAN APPLICATION

K-BEN 101 (Rev. 06-2009)

RETURN TO: Shared Work Program - Benefits
401 SW Topeka Boulevard
Topeka, KS 66603-3182
FAX: (785) 296-4269

Return this completed application as directed above. A determination of your company's eligibility to participate in the Shared Work Program will be made and you will be notified by letter.

A EMPLOYER INFORMATION

Company name: Employer Serial Number:

Preferred mailing address: Street **OR** P.O. Box Number City

State: Zip +4: Phone:

Affected Unit: Number of workers: Number of affected workers:

Regular work hours per week: Plan to reduce hours from: % to %

Will reduction in hours affect participating employees' fringe benefits? YES NO If YES, explain:

B EMPLOYER CERTIFICATION (To be completed by the person authorizing the implementation of the program)

I certify that the implementation of this Shared Work Plan and the resulting reduction in work hours is in lieu of temporary layoffs that affect at least 10% of the affected unit. I have provided a list identifying the affected employees by name and social security number. I understand that during the time the Shared Work Plan is in effect, the Kansas Department of Labor (KDOL) will submit a list of those employees in the affected unit to me weekly. I am responsible for completing the form and mailing it directly to KDOL every week.

Printed name: Title:

Employer or representative signature:

Date (mm dd yyyy): E-mail:

C COLLECTIVE BARGAINING INFORMATION (If there is such an agreement, to be completed by bargaining unit)

Union name: Local number:

Union official: Title of official:

Signature: Date (mm dd yyyy):

FOR AGENCY USE ONLY

Application received: _____ Employer current? YES NO Initials _____ Date: _____

Reduced weekly hours: _____ Normal weekly hours: _____ Payroll week ending: _____

Determination: Denied Approved Beginning date: _____ Ending date: _____

Reason for denial: _____

Examiner: _____ Date: _____ **PLAN NO.** _____ **SUB PLAN NO.** _____

D IDENTIFICATION OF AFFECTED EMPLOYEES

EMPLOYEE NAME	SOCIAL SECURITY NUMBER